Lifetime Legacy®

Application Packet

This packet contains the basic forms needed to write Lifetime Legacy. For additional information, contact Sales Support at 800.231.0801 or log on to *www.americo.com*.

Forms included in this packet:

- Lifetime Legacy Disclosure and Benefit Worksheet (04-090-1)
- Lifetime Legacy Application (Series 5090)
- Disclosure Statement for Accelerated Benefit Payment Rider (Series 8398)

Additional forms that may be required:

These forms can be ordered or downloaded from *www.americo.com*.

- Replacement Forms – Required in applicable states when replacing an existing life insurance policy or annuity contract. Important Note: States may require a completed replacement form even when an existing policy or contract is not being replaced. Contact Sales Support for additional information. State variations apply.
- HIV Consent Forms (Series 8285) – May be required in applicable states due to underwriting. State variations apply.
- Transfer Funds Form (15-119-1)– Required for full or partial surrender of an annuity or other financial account(s) if the client plans to have funds transferred directly from their financial institution to Americo.

AMERICO®

For Use in Massachusetts
12-066-37-MA (06/16)

Application/Document

Transmittal Form

AFSFAX2002 (01/16)

Your application(s)/document(s) can be submitted through the following methods:

- Toll Free Fax Numbers:
  800.395.9261, 800.395.9238, or 877.388.3448
- E-mail: submit@americo.com
- Web Upload: www.americo.com

If this form is completed and used as your cover sheet for a new policy application, you will receive a confirmation message with the policy number by fax or e-mail. Confirmation will be delivered the same day if the application is received by 5 p.m. CST/CDT or the next business day if received after 5 p.m. CST/CDT. If you have any questions or need assistance with the submission process, please feel free to call the Agent Contact Center at 800.231.0801.

When submitting applications via web upload or e-mail, please note that the maximum file size we can accept is 25MB. In addition, we accept the following file types: PDF, TIFF, or JPEG.

PLEASE PRINT LEGIBLY

Agent / Agency Name:	Agent / Agency Phone Number:	Total No. of Pages Sent:
Fax Number and/or Email Address to Send Confirmation to:	Agent Code:	

Policy Number (if Applicable)	Applicant / Insured Name	Notes

Disclosure for
Lifetime Legacy

AMERICO

Is Lifetime Legacy Right for You? *Required*

This disclosure must be signed and submitted with the application.

Lifetime Legacy is a specially designed life insurance policy for wealth transfer planning. Compared to many other financial products, repositioning some of your assets into Lifetime Legacy may allow you to pass on a larger, generally income tax-free benefit to your loved ones. Lifetime Legacy is not for everyone. You should ask yourself these important questions to determine if this policy is right for you:

Do I have assets set aside that I plan on passing on to my loved ones? ☐ Yes ☐ No

Aside from these assets, do I have financial resources that are more than adequate to support my daily needs? ☐ Yes ☐ No

I have identified assets that I will not need to support my daily needs and want to use these funds to purchase a Lifetime Legacy life insurance policy that may help me pass on more wealth to my loved ones.

Proposed Owner's Signature (Required) _____ Date _____

Benefit Worksheet *Optional*

Proposed Insured: _____ Age: _____ Sex: ☐ M ☐ F Tobacco Use: ☐ Yes ☐ No

Asset Type	Gross Value	- Penalty Charges	- Tax Liability[1]	= Net Value
_____	$ _____	$ _____	$ _____	$ _____
_____	$ _____	$ _____	$ _____	$ + _____
				$ _____ Total assets to reposition
				$ ÷ _____ Single Premium Factor

Initial Guaranteed Minimum Death Benefit[2,3] $ _____

$ - _____ Total assets to reposition

Immediate increase to my estate with Lifetime Legacy $ _____

Living Benefits _____ (Initial Guaranteed Minimum Death Benefit[2,3]) X 80%* = _____ (Accelerated Benefit Amount[3])

*Up to 80% of the guaranteed minimum death benefit less any loans is available to you should you become permanently confined to a qualified nursing facility, or if you are diagnosed with a qualifying terminal illness.[4] The maximum Accelerated Benefit Amount available is $250,000.

Lifetime Legacy (Policy Series 258) is underwritten by Americo Financial Life and Annuity Insurance Company, Kansas City, MO, and may vary in accordance with state law. Products may not be available in all states. Riders are available for an additional cost, unless otherwise noted, and may not be available in all states. Certain restrictions apply. Consult policy and riders for all limitations and exclusions.

Lifetime Legacy may be designated a Modified Endowment Contract (MEC). Distributions of gain are subject to income taxation rules and IRS early distribution penalties. Please consult your tax advisor for further details.

All information shown here is hypothetical, intended for illustrative purposes only, and not guaranteed.

[1] *Surrender charges and tax liability may be estimates based on information you've provided. Please note that withdrawing funds from or surrendering annuities or life insurance may be subject to immediate tax consequences and surrender or withdrawal charges. Neither Americo nor any agent representing Americo is authorized to give legal or tax advice. Please consult a qualified, professional legal or tax advisor regarding the information and concepts contained in this material.*

[2] *The policy's guaranteed minimum death benefit is equal to the initial specified amount as defined in the policy assuming no loans, withdrawals or accelerations of the death benefit are taken. The guaranteed minimum death benefit is guaranteed for the lifetime of the insured, assuming no policy loans, withdrawals, or accelerations of the death benefit have been taken.*

[3] *The quotes presented on this worksheet are based only on the information provided and are not binding. These quotes do not constitute an offer or contract. The coverage ultimately provided may differ based upon your individual circumstances and may vary by state.*

[4] *Accelerated Benefit Payment Rider (Rider Series 2149). Benefits may vary by state and may not be available in all states. Certain limitations and exclusions apply. The permanent nursing home benefit is payable after a 90-day elimination period from the time confinement begins. Because accelerated benefit payments are treated as liens against the policy, interest will apply and will gradually decrease the amount of proceeds payable over time.*

04-090-1(12/07)©Americo

Application for
Individual Life Insurance ICC13 5090 (10/13)

AMERICO
Americo Financial Life and Annuity Insurance Company

1. PROPOSED INSURED INFORMATION

a. Proposed Insured's Name *(Last, First, MI)*

b. ☐ Single ☐ Married

c. ☐ Male ☐ Female

d. Address *(Include City, State, and ZIP. If mailing address is a PO Box, a street address is also required.)*

e. How long at current address? _____ *If less than 5 years at current address, prior address is required.*

f. Primary Phone: ☐Home ☐Mobile ☐Work

g. Alternate Phone: ☐Home ☐Mobile ☐Work

h. Email Address

i. Is the Proposed Insured a U.S. Citizen? ☐ Yes ☐ No

j. Social Security # or Taxpayer ID #

k. Date of Birth (MM/*DD/YYYY*)

l. Age

m. Place of Birth *(City, State, Country)*

n. Employer and employer address *(Include City, State, and ZIP)*

o. Provide description of job duties:

2. PRODUCT INFORMATION *(Verify that the product is available in the state where the application is being signed.)*

a. Product Name: **Lifetime Legacy**

b. Death Benefit: $ _____

c. Premium Mode: **Single Premium**

d. Planned Premium: $_____

e. Premium Class applied for: ☐ Non-nicotine ☐ Nicotine

3a. BENEFICIARY INFORMATION (*Include percentage shares. If shares are not given, they will be equal.)*

If not specified, all beneficiaries will be primary.	Name *(Last, First, MI)*	Email Address	Social Security #/ Taxpayer ID #	Date of Birth	Relationship to Proposed Insured	% of Share *(Must total 100%)*
Primary						
☐Primary ☐Contingent						
☐Primary ☐Contingent						

b. Please choose one: ☐ Beneficiary may elect lump sum settlement or other settlement options available in the policy contract. **OR** ☐ Death benefit to be distributed via monthly installments over a 60-month period.

4. LIFE INSURANCE IN FORCE AND REPLACEMENT INFORMATION

	Yes	No
a. Does the Proposed Insured have life insurance or annuity applications pending with other companies?	☐	☐
b. Are there any existing life insurance or annuity contracts with Americo or any other Company on the life of the Proposed Insured?	☐	☐
*(If **No**, answers to question c., d., e., and f. are No or N/A.)*		
c. Will the life insurance applied for replace, change, or otherwise reduce in value, any existing life insurance or annuity contract now in force with Americo or any other Company?	☐	☐
*(If **Yes to either b. or c.,** provide information below and complete the replacement form(s) in accordance with applicable state replacement regulations. Replacement forms must be submitted with the application. Application and replacement form(s) must be completed and dated on the same day.)*		
d. Is this an internal replacement? *(If **Yes,** include a Surrender form or Absolute Assignment form for the life insurance or annuity being replaced.)*	☐	☐

e. If this is a 1035 exchange, indicate value to be transferred *(include Absolute Assignment form)*. $ _____ ☐N/A

f. If current life insurance or annuity is being replaced, indicate the amount of surrender charges that will be assessed. $ _____ ☐N/A

Proposed Insured's Name *(Last, First, MI)*	Company	Owner	Amount	Accidental Death Benefit	Policy Date *(MM/DD/YYYY)*
			$	$	
			$	$	
			$	$	

5. OTHER INSURANCE

Has the Proposed Insured had an application for life or health insurance or reinstatement declined, rated, or modified in any way? *(If **Yes**, provide details below.)* ☐ Yes ☐ No

Other Insurance Details:

6. OWNER INFORMATION *(If different from the Proposed Insured.)*

a. Owner's Name *(Last, First, MI)*	b. Relationship to Proposed Insured	c. Social Security # or Taxpayer ID #

d. Address *(Include City, State, and ZIP. If mailing address is a PO Box, a street address is also required.)*

e. How long at current address? _____ *If less than 5 years at current address, prior address is required.*

f. Primary Phone: ☐Home ☐Mobile ☐Work	g. Alternate Phone: ☐Home ☐Mobile ☐Work

h. Is the Owner a U.S. Citizen? ..... ☐ Yes ☐ No

i. Email Address	j. Date of Birth *(MM/DD/YYYY)*	k. Place of Birth *(City, State, Country)*

7. MEDICAL HISTORY

a. Proposed Insured's Height ..... ' " b. Proposed Insured's Weight ..... lbs.

	Yes	No
c. Within the past twelve (12) months, has the Proposed Insured used any tobacco or nicotine products in any form?	☐	☐
d. Within the past five (5) years, has the Proposed Insured been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for: high blood pressure; heart disease/disorder; stroke; chronic obstructive pulmonary disease (COPD); emphysema or shortness of breath; lung or respiratory disorder; sleep apnea; cancer; diabetes; kidney disease; liver disease, including hepatitis; Crohn's disease; ulcerative colitis; unexplained weight loss; digestive disorders; bladder disorders; Alzheimer's disease; dementia; taken any prescription medication for Alzheimer's disease, dementia or memory loss; emotional or psychiatric disorder; nervous system disorder; paralysis; circulatory or blood disorders (excluding HIV); lupus; or drug or alcohol abuse? *(If **Yes**, circle all that apply and provide details below.)*	☐	☐
e. Within the past two (2) years, has the Proposed Insured:		
1. been bedridden, confined to a hospital or nursing facility, received hospice or home health care, or used oxygen for assistance in breathing?	☐	☐
2. been advised by a physician to have tests such as an electrocardiogram (EKG), echocardiogram, X-ray and/or blood tests or had tests, surgery, treatment or hospitalization recommended, but not completed (except those tests related to HIV or AIDS)?	☐	☐
f. Has the Proposed Insured ever been diagnosed by a member of the medical profession for Acquired Immunodeficiency Syndrome (AIDS) or AIDS-Related Complex (ARC), or any immune deficiency related disorder, or tested positive for antibodies to the Human Immunodeficiency Virus (HIV)?	☐	☐
g. Does the Proposed Insured currently:		
1. use prescription medication? *(If **Yes**, list each medication with frequency and dosage below.)*	☐	☐
2. have a personal physician? *(If **Yes**, provide name, address and telephone number of personal physician and provide the date, reason, and results of the last consultation.)*	☐	☐
h. Within the past five (5) years, has the Proposed Insured:		
1. made a claim for or received benefits, compensation, or pension for any injury, sickness, disability, or impaired conditions?	☐	☐
2. been unable to work or perform normal activities of like age and gender, or been confined at home?	☐	☐
i. Within the last five (5) years, has the Proposed Insured consulted with a member of the medical profession not already identified for any reason? *(If **Yes**, list name, address, telephone number and provide date, reason, and results of the consultation below.)*	☐	☐

Medical History Details. Please provide details of all "Yes" answers in the area below. *(Attach a separate sheet if more space is needed. Any additional sheet MUST be signed and dated by the applicable Proposed Insured/Owner to avoid amendment.)*

Question #	Date	Details/Results/Medication	Name, Address, and Telephone Number of Attending Physician

8. STATEMENT OF INTENT

State insurance law may prohibit the owner of a life insurance policy from entering into any agreement to sell, transfer or assign a life insurance policy prior to the date the policy was issued, or within a period of time specified by state law after the date the policy was issued. You should consult with legal advisors if you have any questions about these matters. It is Americo Financial Life and Annuity Insurance Company's policy that life insurance should only be purchased to provide protection to those with an insurable interest in the life of the Insured. Americo will not knowingly participate in life insurance sales motivated by a possible sale of life insurance contracts to a secondary market or participation of investors in life insurance benefits.

a. Do you intend to transfer ownership of the life insurance policy to a third party (such as a life settlement company, charity, or investor group)? *(If **Yes**, provide details.)* ..... ☐ Yes ☐ No

b. Has any inducement been offered (direct or indirect) to encourage you to apply for this life insurance policy, such as cash, gifts, or loan proceeds? *(If **Yes**, provide details.)* ..... ☐ Yes ☐ No

c. Will the initial or any future premiums for this policy be borrowed, loaned, or otherwise financed? *(If **Yes**, provide details.)* ..... ☐ Yes ☐ No

Statement of Intent Details:

9. AUTHORIZATION AND ACKNOWLEDGMENT

Information regarding Your insurability will be treated as confidential. Americo Financial Life and Annuity Insurance Company (Americo) is a member of MIB, Inc. (MIB). Americo, and its reinsurers, may make a brief report to MIB, which operates an information exchange on behalf of its members. If You apply to another member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB may supply such company with the information in its file. Americo or its reinsurers may also release information to other insurance companies to whom You may apply for life or health insurance, or to whom a claim for benefits may be submitted. It is Americo's practice to prohibit third parties who lawfully receive nonpublic health information from redisclosing or reusing the disclosed information. You may request to see the information kept in Your MIB file. You may also contact MIB and seek a correction for any errors in Your file.

Your authorization permits any insurance or reinsurance company, licensed medical physician, medical professional, hospital, pharmacy or pharmacy benefit manager, records custodians, other medical or medically related facility, clearing house, consumer reporting agency, and/or MIB, Inc. that has any information about You, or anyone listed in this application that are proposed to be insured, to give Americo, its reinsurers and/or potential reinsurers, or its authorized representatives, information about other insurance coverage, age, general character, habits, medical care or advice about any physical or mental condition, including information about drugs and alcoholism, required by Americo to determine insurability and/or claims eligibility, for the duration of the claim. Health information obtained will not be re-disclosed without Your authorization unless permitted by law, in which case it may not be protected under federal privacy rules.

You, or Your authorized representative, may obtain a copy of this Authorization on request. This Authorization will be valid for two (2) years from the date signed. This Authorization may be revoked; however, it may not be revoked during the contestability period of the policy or to the extent Americo has taken action in reliance on this Authorization. Notice of revocation may be sent, in writing, to Americo at its Administrative Office address.

FRAUD NOTICE: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

The **USA PATRIOT ACT** requires all financial institutions, including insurance companies, to verify the identity of their customers. Providing your name, address, date of birth, and taxpayer identification number allows us to verify your identity. Our verification process may include the use of third-party sources to verify the information provided.

REQUEST FOR OWNER(S) TAXPAYER IDENTIFICATION NUMBER AND W-9 CERTIFICATION: Under penalties of perjury, I as the Owner certify that:

1. **I am a U.S. citizen or other U.S. person, and the number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me); and,**
2. **I am not subject to backup withholding because: (a) I am exempt from backup withholding, or (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding.**

CERTIFICATION INSTRUCTIONS: You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return.

No agent or medical examiner can waive the answer to any question in this application nor decide on insurability nor waive any of the Company's underwriting requirements nor make or change any contract. The Company shall have no knowledge of statements made by or to the Agent or medical examiner unless such statements are shown on the application. The Company will have no liability until a policy is issued on this application and delivered to and accepted by the Owner, and the first premium due is paid in full while the Proposed Insured is alive.

UNDERSTANDING ABOUT THIS LIFE INSURANCE APPLICATION: I understand that I have applied for a life insurance policy. The policy is designed for long-term buyers who seek life insurance protection and benefits. The asset(s) used to purchase the life insurance policy is not needed by me (or my spouse) for retirement income or emergency needs. I have determined that this policy is appropriate for my insurance and financial needs and objectives.

I acknowledge and understand that the proposed plan of insurance may be a Modified Endowment Contract and may be subject to special tax treatments.

I have read this application and represent to Americo that the statements made on this application are true, complete and correctly recorded to the best of my/our knowledge and belief. I agree that Americo can rely on these statements. I agree that this application and/or any medical exam form and any supplemental application or amendment to the application will be the basis for any policy issued on this application or any amendment to the application. **I AGREE THAT ALL ANSWERS TO THE QUESTIONS IN THIS APPLICATION, SIGNED AND DATED BELOW, ARE COMPLETE AND ACCURATE.**

Signed at (City and State) _____ on (Month/Day/Year) _____

X _____
Signature of Proposed Insured *(required)*

X _____
Signature of Owner (*if different than the Proposed Insured)*

X _____
Signature of Witnessing Agent *(required)*

AGENT'S REPORT

Important Note: Agent's Report must be completed and submitted with all applications

Proposed Insured's Name:_____

	Yes	No
1. Are you related to the Proposed Insured? If **Yes**, provide relationship: _____	☐	☐
2. How long have you known the Proposed Insured? _____		
3. Did the applicant approach you to purchase insurance? *(If **Yes,** list their stated need for the insurance in the Agent Comments/Remarks section below.)*	☐	☐
4. At the time this application was taken, were all of the Proposed Insureds present and did you witness their signatures?	☐	☐
5. Did the Proposed Insured directly respond to you regarding each application question?	☐	☐
6. Was a government-issued picture ID requested, reviewed, and confirmed (by reviewing a second document such as a utility bill, tax return, etc.) for the Proposed Insured, Owner, and Payor *(if different than the Proposed Insured)*?	☐	☐

Provide details of all NO answers to questions 4-6 in the Agent Comments/Remarks section below.

Replacement Information	Yes	No
7. Are there any existing life insurance or annuity contracts with Americo or any other Company on the life of the Proposed Insured? *(If **Yes,** leave copies of sales materials with Owner. If you used an electronic sales presentation, you must mail a copy to the Owner.)*	☐	☐
8. Will the life insurance applied for replace, change, or otherwise reduce in value, any existing life insurance or annuity contract now in force with Americo or any other Company?	☐	☐

*(If **Yes to either 7. or 8.,** complete the replacement form(s) in accordance with applicable state replacement regulations, and if you used an electronic sales presentation, you must mail a copy to the Owner. Replacement forms must be submitted with the application. Application and replacement form(s) must be completed and dated on the same day.)*

Agent Comments/Remarks:

I hereby certify that I have personally asked each question on this application to the Proposed Insured, that I have truly and accurately recorded on the application the information supplied by him/her, and that I have no reason to believe that any of the information provided is inaccurate or incomplete. If not, I have set forth my reservations in the "Agent Comments/Remarks" section above.

Print Agent's Name	Agent's Signature	Americo Agent Number	% Split
	X		
	X		
	X		

Writing Agent's Phone Number	Writing Agent's Fax Number	Writing Agent's Email Address

Does Americo have your current contact information? If not, Email: nbdi@americo.com.

REQUIRED DISCLOSURE STATEMENT FOR ACCELERATED BENEFITS

LIMITATIONS OF THE ACCELERATED BENEFIT

The accelerated benefit in this life insurance product may provide benefits to pay for long-term care services, but it is NOT part of a long-term care or nursing home insurance policy and the amount this product pays you may not be enough to cover your medical, nursing home or other bills. You may use the money you receive from this product for any purpose, unless, according to federal definitions, you qualify for benefits because of a Chronic Illness. If you qualify for benefits because of Chronic Illness, you may use the benefits to pay for Qualified Long-Term Care Services only. **Unlike conventional life insurance proceeds, accelerated benefits payable under this product rider COULD BE TAXABLE IN SOME CIRCUMSTANCES.** We recommend that you contact a tax advisor when making tax-related decisions about electing to receive and use benefits from an accelerated benefit product.

A. CONSEQUENCES OF THIS BENEFIT

Receipt of accelerated benefits MAY AFFECT MEDICAID and SUPPLEMENTAL SECURITY INCOME ("SSI") ELIGIBILITY. The mere fact that you own a policy with an accelerated benefit product may affect your eligibility for these government programs. In addition, exercising the option to accelerate death benefits and receiving those benefits before you apply for these programs, or while you are receiving government benefits, may affect your initial or continued eligibility. Contact the Medicaid Unit of your local Division of Medical Assistance and the Social Security Administration for more information.

B. MEDICAL CONDITION(S) ENABLING ACCELERATING OF LIFE BENEFIT

A non-correctable medical condition that, with reasonable medical certainty, will result in death in 24 months or less. We must receive a written statement from a Physician certifying the Insured's medical condition and the Insured's life expectancy.

C. OPTION(S)

The Owner may request up to 80% of the result of (a) minus (b) as of the date the request is received, where: (a) is the Specified Amount; and (b) is any outstanding policy loans. The maximum Accelerated Benefit payable is $250,000 with a minimum available payment of $5,000.

The Owner may elect the Accelerated Benefit payment as a lump sum or equal periodic payments. Equal periodic payments may be paid quarterly or semi-annually over a period of twelve (12) months. During the payment period the Owner may elect to receive the remaining Accelerated Benefit payments as a lump sum.

D. PREMIUM FOR ACCELERATED BENEFIT

There is no premium or Cost of Insurance for the Accelerated Benefit Payment Rider.

E. ADMINISTRATIVE FEE

An administrative fee not to exceed $250 will be assessed at the time the Accelerated Benefit is paid.

_____ _____

Proposed Insured's Signature Date

_____ _____

Owner's Signature (if other than Proposed Insured) Date

_____ _____

Agent or Broker's Signature Date

No Premium

Conditional Receipt

IMPORTANT NOTICE — PLEASE READ CAREFULLY!

NO INSURANCE WILL BE PROVIDED UNLESS ALL TERMS STATED BELOW ARE MET EXACTLY AND IN FULL! NO AGENT OR BROKER HAS THE AUTHORITY TO CHANGE OR WAIVE ANY OF THESE TERMS. NO INSURANCE PREMIUMS HAVE BEEN RECEIVED WITH THIS APPLICATION.

1. ALL OF THE FOLLOWING TERMS MUST BE MET EXACTLY AND IN FULL BEFORE COVERAGE WILL BEGIN:
   (A) Payment of the first full modal premium is received by the Company;
   (B) All medical examinations, X-rays, tests, physicians' statements and any other underwriting requirements of the Company must be received; and
   (C) The Proposed Insured in the application must be acceptable to the Company without change on the Effective Date under its rules for insurance (1) on the Plan applied for (2) in the amount and (3) in a premium class not less favorable than the premium class applied for and with no ratings.
2. **IF PREMIUM PAYMENT IS RECEIVED BY THE COMPANY AND ALL OF THE REQUIREMENTS IN (B) ABOVE ARE NOT RECEIVED BY THE COMPANY WITHIN THE FOLLOWING 60 DAYS, THE APPLICATION WILL BE VOID AND THE PREMIUM WILL BE RETURNED.**
3. **IF ANY PROPOSED INSURED DIES DURING THE PROCESSING OF THIS APPLICATION AND BEFORE ALL OF THE FOREGOING TERMS HAVE BEEN MET, NO INSURANCE COVERAGE WILL EXIST, AND THE COMPANY'S ONLY LIABILITY WILL BE TO REFUND PREMIUMS RECEIVED, IF ANY.**
4. If all requirements are met, the "Effective Date" will be the later of: (1) the date all of the above required information is received by the Company or (2) the date of issue.

Signed at (City and State)_____ on (Month/Day/Year) _____.

X _____ Signature of Licensed Agent

X _____ Signature of Applicant

THIS IMPORTANT NOTICE IS APPLICABLE IF NO PREMIUM IS RECEIVED WITH THE APPLICATION.

Premium

Conditional Receipt

THIS IS A CONDITIONAL RECEIPT — PLEASE READ CAREFULLY!

NO INSURANCE WILL BE PROVIDED BY YOUR FIRST PAYMENT UNLESS ALL TERMS IN PARAGRAPH "FIRST" ARE MET EXACTLY AND IN FULL! NO AGENT OR BROKER HAS THE AUTHORITY TO CHANGE OR WAIVE ANY OF THESE TERMS.

Received from _____ on (Month/Day/Year) _____ $_____ by check, preauthorized order for withdrawal, or salary deduction plan. This payment is the amount of the first full modal premium for the policy applied for in the application for life insurance to Americo Financial Life and Annuity Insurance Company having the same number and date as this Conditional Receipt. This payment is made and accepted under the terms of this Conditional Receipt. This Conditional Receipt cannot be transferred. ANY PAYMENT BY CHECK MUST BE MADE PAYABLE TO AMERICO FINANCIAL LIFE AND ANNUITY INSURANCE COMPANY. DO NOT MAKE ANY CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK. If your check or draft is not honored when first presented for payment, this Conditional Receipt will not be valid.

FIRST: TERMS ALLOWING INSURANCE TO BECOME EFFECTIVE BEFORE POLICY DELIVERY: If ALL of the following terms are met exactly and in full, insurance under the terms of the policy applied for, if then being sold by the Company, will become effective on the Effective Date subject to the limitations in Paragraph "SECOND": (1) All representations made in the application must be true and complete in all material respects; (2) all medical examinations, X-rays, tests, physician's statements and any other underwriting requirements of the Company must be completed and received not later than 60 days from the date the application is signed; (3) all persons proposed for insurance in the application must be acceptable to the Company without change on the Effective Date under its rules for insurance (A) on the Plan applied for (B) in the amount and (C) in a premium class not less favorable than the premium class applied for and with no ratings; and (4) the amount shown above must be equal to at least the first full modal premium for insurance.

IF ANY PROPOSED INSURED DIES DURING THE PROCESSING OF THIS APPLICATION AND BEFORE ALL OF THE FOREGOING TERMS HAVE BEEN MET, NO INSURANCE COVERAGE WILL EXIST, AND THE COMPANY'S ONLY LIABILITY WILL BE TO REFUND PREMIUMS RECEIVED, IF ANY.

IF ALL OF THE TERMS ABOVE ARE NOT MET EXACTLY AND IN FULL, THE COMPANY'S ONLY LIABILITY WILL BE TO REFUND THE AMOUNT FOR WHICH THIS CONDITIONAL RECEIPT WAS GIVEN. "Effective Date" means the latest of: (1) the date the application is signed; (2) the date all required information is completed and received by the Company; and (3) the date of issue.

SECOND: LIMITS OF LIABILITY — MAXIMUM AMOUNT OF INSURANCE AND PERIOD OF TIME WHICH INSURANCE CAN BECOME EFFECTIVE BEFORE POLICY DELIVERY. The Company's liability for insurance under this Conditional Receipt plus all insurance which is in force or is pending in the Company on any Proposed Insured can never exceed $250,000 of life insurance including (a) Accidental Death Benefits, and (b) any coverage in force. The time for which the Company can be liable under this Conditional Receipt can never exceed a period of 60 days from the date this Receipt was signed.

Signed at (City and State)_____ on (Month/Day/Year) _____.

X _____ Signature of Licensed Agent

X _____ Signature of Applicant

If the application is not approved and accepted within 60 days from the date it was signed, the Company shall have no liability except for the return of this payment on surrender of this Receipt.

Important
Consumer Notices

AAA8402 (05/16)

AMERICO

INFORMATION PRACTICES NOTICE

THIS NOTIFICATION MUST BE DELIVERED TO THE PROPOSED INSURED WHEN THE APPLICATION IS COMPLETED.

Thank you for your application. This notice is given to you at the time you apply for life insurance to tell you about the kinds of information we may obtain in connection with your application. We rely primarily on information provided by you. We may also collect information from others, such as medical professionals who have treated you, hospitals, other insurance companies, and consumer reporting agencies. In certain limited situations, we are allowed by law to disclose necessary items of personal information to third parties without your specific authorization. You have a right of access and correction with respect to this information. You have the right to receive, in writing, the specific reason for an adverse underwriting decision. If you wish a more detailed explanation of our information practices, please write us at: Americo Financial Life and Annuity Insurance Company, PO BOX 410288, Kansas City, MO 64141-0288, Attention: Underwriting/New Business Department. Any requests to correct, amend or alter will be responded to within 30 days. Information that is corrected will be provided to any person who is designated by the requesting party and who may have received the information in the prior two years (within a 7-year timeframe). Any statement of disagreement made by a requesting party will be filed and made available to those reviewing it in the future.

MIB, INC. PRE-NOTICE

Information regarding your insurability will be treated as confidential. However, Americo Financial Life and Annuity Insurance Company or its reinsurers may make a brief report to the MIB, Inc. formerly known as Medical Information Bureau, a nonprofit membership organization of life insurance companies operating as an information exchange for its members. If you apply to another MIB member company for life or health insurance or a claim is submitted to such a company, upon request the MIB will supply the company with the information it has in its file.

Upon receipt of a request from you, the MIB, Inc., will arrange disclosure of any information it has in your file. Please contact MIB at 866.692.6901 (TTY 866.346.3642). If you question the accuracy of information in the file, you may contact the MIB and seek a correction in accordance with the procedures in the Fair Credit Reporting Act. The MIB's information office address is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. The Company or its reinsurers may release information in its file to its reinsurers and to other life and health insurance companies to whom you apply for insurance or to whom a claim is submitted. Information for consumers about MIB may be obtained on its website at *www.mib.com*.

INVESTIGATIVE CONSUMER REPORTS

We may make or obtain an investigative consumer report, which may contain information secured through personal interviews with your friends, neighbors and others with whom you are acquainted. This report may contain information as to your character, general reputation, personal characteristics and mode of living. The consumer reporting agency may keep a copy of the report and may disclose its contents to others for whom it performs such services. On receipt of a request from you, we will tell you if a report has been requested and we will provide you with the name, address, and telephone number of the consumer reporting agency. You may request to be personally interviewed and, when the report is completed, you have a right to inspect and receive a copy of it from the consumer reporting agency. Please send your request to: Americo Financial Life and Annuity Insurance Company, PO BOX 410288, Kansas City, MO 64141-0288, Attention: Underwriting Department.

NOTICE REGARDING MODIFIED ENDOWMENT CONTRACTS

The Technical and Miscellaneous Revenue Act of 1988 (TAMRA) created a class of life insurance policies called Modified Endowment Contracts (MEC). Generally, a life insurance policy is a MEC if the policy is purchased with a single premium or premium payments which exceed the limits prescribed by this law.

If this policy is or becomes a MEC, policy loans, withdrawals, assignments and surrenders will be taxed as income to the extent that there is a gain in the contract. There is gain in the contract if the cash values exceed the cost basis in the policy (generally the premiums paid). In addition, you must pay a 10% tax penalty on the taxable portion of any policy loan, withdrawal, assignment or surrender made by you before age 59½. This information is merely a summary of Internal Revenue Code rules which govern life insurance policies. As with all tax matters, you should seek the advice of a qualified tax advisor. By my signature on the attached application, I acknowledge the policy issued from this application may be issued as, or may become, a Modified Endowment Contract.